How do members of service professions see themselves, their clients, and the relationships between them? Where and how are such views acquired? And how do they influence professional behavior? Some aspects of this larger problem are presented here in terms of dental students.

THE DENTAL STUDENT IMAGE OF THE DENTIST-PATIENT RELATIONSHIP

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THIS is a report on some aspects of what dental students learn in professional school. However, it does not focus on what they are taught at the manifest level by way of instructors and texts. Rather it concentrates on what students latently learn as a result of their informal as well as formal school experiences.

This report is based on a much broader sociological study which examined what was involved in becoming a dentist.[1] In that study an attempt was made to obtain a picture of what occurred to recruits into dentistry as they proceeded through dental school. An examination was made of this educative experience as it was perceived by the students themselves. What is reported in this paper is limited primarily to the images student-dentists acquire regarding several aspects of the dentist-patient relationship. Reports on other facets of the socialization process undergone in the professional school are presented elsewhere.[2]

To understand the perception of dental students regarding the dentist-patient relationship, it is necessary to analyze their perception of both parties involved, as well as their conception of the relationship itself. Thus, we will first examine the self-conception of students regarding their dental work role as they see this role from the viewpoint of others. (This is based on the well established fact that the interaction of persons in a social relationship is very heavily influenced by the image that one person believes is attributed to him by the other person.[3]) We will then examine how the relationship itself between practitioner and patient is seen. Finally, we will examine how patients as patients are visualized. To summarize, we will analyze how student-dentists perceive themselves, the people on whom they work, and the link itself between themselves and those people.

This report is based chiefly on data from interviews, averaging around an hour and a half in length, with 160 statistically chosen respondents drawn from the students at a state and at a private school. The stratified random sample obtained comprised 28 per cent of the universe studied. All designated respondents were interviewed and a very high degree of rapport was obtained in almost all instances. To insure adequate coverage for comparative purposes, a pretested interview guide was used, but questions and probes were left as unstructured as possible. The interview

protocols were subjected to both a quantitative and qualitative analysis. In what follows, limitations of space will prevent the presentation of more than selected and illustrative data from which the findings were derived, but full details are available in the original source document.[4]

Self-Image

Almost all dental students perceive themselves entering a profession about which they feel the public has at least some definitely unfavorable views. Only 10 per cent of our respondents, for instance, believed that people had a generally favorable image of the dentist. In contrast, more than three times as many thought that people had a generally unfavorable view. The rest visualized a mixed image.

Do people really have unfavorable images of dentists? For some social-psychological purposes this is not too important a question. If people define a situation as real, it is real in so far as it has consequences for their behavior and also for understanding that behavior.[5] If you believed a building were on fire, you would act on that belief. In order to understand your behavior it would be necessary to take into account this belief of yours even though it were a mistaken one. Similarly, student-dentists believe people do have a negative image. They act on the basis of this image, and their behavior can only be understood by taking into account the fact that they so define the situation.

In itself a certain degree of negative self-perception about one's work activities is not unique. Sociological studies of various service occupations indicate this rather clearly.[6] Most workers in any given field believe the public at large does not have as favorable an image of the occupational role as the workers in the activity believe they should have. This is true whether the people involved be physicians or janitors, school teachers or call girls.

However, dental students necessarily perceive this lack of appreciation and understanding on the part of the people they service much more than even other professional students, because they have maximum interaction with patients while still in dental school. To be sure, the student is under supervision and nominally at least can do no dental work without the written permission of a dental instructor. Still, the senior dental student performs dental operations and engages in dental work that differs in no way from what a licensed practitioner does except that the student does it within the confines of a school clinic.

The same cannot be said about medical, nursing, law, engineering, teaching, pharmacy, and other professional students. In a way, their training, particularly in relation to future recipients of their service, is much more abstract and remote; it does not partake of the same continuous and realistic on-the-job-like kind of dealing with patients that the dental student undergoes. There is little if any gap between what a dental student does and what a licensed practitioner does, compared with, for example, the large differences between what a medical student does and what a licensed physician does.[7] It is because of this that we say that a negative self-image of the work role they will assume necessitates more of a reaction from dental than it would for other professional students. In their clinic work role, students see themselves as being responded to along certain lines as dentists. Since they believe the response is negative, they have to learn to adjust to it.

We will examine something of what is involved by first looking at the different dimensions of the self-image, and second, by seeing what kind of responses are made.

There are three aspects to the negative self-image. Thus, 60 per cent of

our respondents felt the public thought the dentist had only mechanical skills. About 44 per cent believed people took an unfavorable view of dentists because of the physical pain involved in much dental work. And finally, 32 per cent saw people as reacting negatively because supposedly high fees were charged. The negative self-image of dentists therefore is a compound of the supposed belief of actual and potential patients, that dentists are individuals who hurt people while doing mechanical work for which they charge too much. Or as one dental student phrased it: "The average person thinks you are an overcharging, sadistic, mouth plumber."

In the face of supposed negative attitudes of others toward one-self (especially one's work role), how do people generally react? In some rare instances, the negative attitude of others is incorporated into the self-conception in such a way that it may become a source of pride. One finds this for example among some criminal occupations.[8] However, in the vast majority of cases, negative attitudes of others are dealt with in such a way so as to soften their unfavorable impact. This is true of the student-dentist. While recognizing the supposed negative view of others, he acquires through his professional school experiences an interpretation of these attitudes that can be made consistent with the desire for a positive self-conception. What is meant by this can be seen by separately examining the learned reaction to each dimension of the negative self-image.

Physical Pain—The charge of inflicting pain on others is neutralized in three ways: (1) About 30 per cent of our respondents, who felt people negatively viewed dentists because of the pain they occasioned, denied that pain is seriously involved in almost all dental work. The position is taken that people greatly exaggerate its appearance or that it cannot appear because of the modern technics available to prevent it. In either case, the denial of the possibility serves to excuse the dental practitioner from feeling responsible for any complaints about severe pain that are voiced. As one respondent said:

> "A lot of pain is just their imagination but they'll be darned before they'll believe that. Some of them start to feel it before you pick up an instrument. It's never half as bad as they claim it is, and most times you know it just isn't there physically. It's all in their heads."

(2) Sometimes the point is granted that pain is involved in dental work, but the major responsibility for its appearance is placed on the patient himself. Interestingly enough, it is among the better students that blame is most often displaced from practitioner to patient. Essentially the argument is made that a dentist is not to be blamed if a person permits his dental condition to deteriorate to a point where it will hurt when any work has to be done. One of our respondents stated it in just such terms:

> "The great majority of people have a definite fear and that's what leads to what they are afraid of in the first place. They are afraid of going and so their mouths become atrocious. So when they finally do go to the dentist they have a lot of trouble and pain. The dentist can't help hurting them when they've let their mouth condition slip the way they have. If it hurts, it's their own fault for waiting."

(3) Finally, there are those students who neither deny infliction of pain nor displace blame for its appearance. The general position they take is that pain is not a deliberate end in itself. Rather it is an unavoidable but necessary means to a more desirable end. However, even those student-dentists who believe this are exceedingly reluctant to interact with patients on such an explicit basis. The reason for this is unclear. Some of our data suggest that there is an unwillingness to voice this attitude because it will call attention to what otherwise might remain dormant.

In all three reactions cited, it is clear that there is a discrepancy between the reality perceived by students and that perceived by patients. At least two points are involved. One is that pain and dentistry are inexorably linked by many people. Leaving aside personal experiences, the pain of dentistry is constantly asserted in the mass media, in cartoons, and in popular jokes. To deny, minimize, or excuse the painful aspects of dentistry is to deny the reality of the world as most people see it. As said earlier, if a person defines a situation as real, it is real in so far as consequences are concerned.

Moreover, the matter of routine and emergency is involved here.[9] In many ways, the routine work of the dental practitioner is made up of the emergencies of his patients. This is a frequent source of conflict in health service occupations if not all service occupations. The person with the health problem feels that the health practitioner belittles his trouble when he treats it, as he necessarily must, in a routine way as a case similar to many others. To insist additionally that the patient is exaggerating the painfulness of his troubles or that it is his own fault is, so to speak, adding insult to injury.

Only Mechanical Skill—Nearly two out of three of our respondents felt that the dentist is unfavorably viewed because he is thought to have only mechanical skills. The word "only" is important. There is resentment to references about mechanical skills because it is perceived as a denial of the professional status of dentistry, and as carrying an implication that dentists are trying to claim more for their work than is actually involved. As one respondent commented:

"Many people think of him as a mechanic working in spit like an auto mechanic working in grease. Heck, he's a professional man with a lot of skills that have taken him a long time to acquire. It's not like on-the-job training like in a garage. He knows much more, and he's got many more skills than just the mechanical ones. As a matter of fact they are rather minor. The dentist isn't just a mechanic."

The typical reaction to the "mechanic" image is well indicated in the quotation. Its validity is flatly denied. In fact, on few matters have students in dental school acquired a stronger attitude. This is understandable because unlike the charges of pain and high fees, this is one that their very training most clearly contradicts in many ways. However, as the following quotations illustrate, student-dentists have a great deal of difficulty in convincing people that dental practitioners are more than mechanics.

"A lot of them are amazed to know what you have to do in school. Things like making a complete dissection, attending autopsies, and so on. There's amazement over that. They don't understand the education you get. Even my folks don't seem to understand all that is involved and it always shows up in discussions with friends. When you talk about the science courses they ask when are you going to start training to be a dentist."

"They don't know all that is involved. People think we start right into dentistry and don't know about the basic sciences. For example, when we talk about anatomy people will ask what good is cutting up a person—what good is that for a dentist? But explain to them as much as you will, they can't seem to see what anatomy, biochemistry, physiology, and the rest of the science courses have to do with filling teeth. You get the impression that they feel that somehow it's all unnecessary and that something must be wrong somewhere along the line. One person even said that state schools have so much money, that they must spend it in some way!"

Fundamentally involved here is a basic lack of agreement about the presumed aim of dentistry. Generally speaking, the student conceives the major task of dentistry as that of preventing dental disorders. People in general however apparently visualize dentistry mostly as a reparative rather than preventive type of activity, and thus of a "mechanical" nature. The over-all result is that in still another area practitioners and patients operate with different frameworks and consequent misunder-

standing. The dentist who insists he is not a mechanic is denying what a patient may believe should be his area of competency. In turn, the refusal of the practitioner to accept the mechanic designation given him by patients even more obviously rests on the difference in emphasis regarding repair or prevention.

High Fees—About one of every three of our respondents felt that the dentist was unfavorably viewed because of the high fees that people believed he demanded, especially in relation to the work performed. The issue is seen as one of presumed disparity rather than cost as such. As one respondent said.

"Most of them think dentists live nice, big, soft lives. Not that they exactly think that they steal money, but most people don't feel that dentists give them their money's worth of service."

There are three major reactions to this unfavorable image of a person who demands more in financial return than he is thought to be worth: (1) A blanket denial is made that fees are excessively high for the service rendered. Such denials very often use medicine as a standard of comparison. It was put this way by one respondent:

"People are willing to go to a physician for a physical and pay $5 without question for the checkup. But if they go to a dentist for a checkup they yell about it because they say he hasn't done anything. They have the wrong idea there. Dollar for dollar, the dentist gives a much better bargain."

(2) Occasionally it is admitted that fees are high, but they are justified as necessarily so. It is said a dentist is entitled to charge high fees because, like a physician, he has had to learn very complicated skills, or the professional education required is very costly. Few student-dentists would express themselves so openly to a patient in the way indicated in the following quotation, but it is often a basic underlying attitude regarding the formal education required to become a dentist.

"I do quite often run across some wild ideas. Some person will say he had to pay $6 or $10 to get a tooth filled. Now maybe that's not cheap. But I figure I'll have spent $50,000 in money in predental, here, in the equipment I'll have to buy, and the money I could have been earning all the time. This is what I've lost. The public doesn't realize what it costs to become a dentist. It's only fair that I should charge what I needed for my education. It's unfortunate that some people can't pay high fees, but someone has to pay for my education."

In the two reactions indicated above, students make an assumption that both parties—patients and practitioners—are using the same standard of comparison and evaluation. This is doubtful. Dental practitioners place themselves in the same professional category as physicians. But even the vast majority of our respondents, 87 per cent of them, said that few persons evaluate the dentist as highly as the physician. Likewise, the "mechanic" image of dentistry discussed earlier does not suggest that dental practitioners really believe patients attribute to them the same level of formally learned skills as is attributed to physicians. The denial and/or justification of high fees consequently is from a different framework than that used by patients.

(3) About 33 per cent of our respondents who said people had an image of a dentist as a person who charged high fees, said the accusation was true but only in a limited sense. Thus, some dentists overcharge but they are in the minority. The position is taken that it is unfair to categorize all dentists as "chiselers" because of the actions of a few. Here, instead of justifying or denying the accusation, it is displaced on to a limited number of persons in the profession. Or as stated in an interview:

"Sure, there's no question that sometimes fees are exorbitant. But that's because you have a few crooks in dentistry like you find in any other field. Why should all dentists take the blame for a few bad apples?"

This may be a logical defense. However, it ignores a social psychological aspect of the practitioner-patient relationship. In the health area most persons already feel themselves at the mercy of the professional.[10] Obviously they would not go to a dentist if they felt they could solve the dental problem themselves. To take the position indicated is to say that in addition to trusting the competence of the practitioners they choose, patients will also have to take a chance on their honesty.

Images of the Relationship Itself

The dentist works alone. In few other occupations and in no other profession is the practitioner so independent of colleagues, auxiliary workers, and even clerical personnel. In fact, dentists are closer to the ideological model of the private entrepreneur than are physicians who are often cited as good examples of the model. The average physician is part of a network of professional relationships involving hospitals, specialists, and medical technologists.[11] In contrast, the professional relationships of the vast majority of dentists are almost exclusively with their patients and no one else.

The novice when he enters dental training does not think of this. For example, only 23 per cent of our respondents said the independence of the dentist was a reason for their entry into the field. Actually freshmen have only the vaguest and most nebulous of images of patients and how a dentist relates to them. The exclusiveness of the patient-practitioner relationship only starts to become apparent to the student when he first begins to work in the clinic.

However, more important than the growing awareness by the student that his professional work relationships are confined almost exclusively to his patients is the kind of relationship that is visualized. Students acquire different images. These are derived not so much from personal contact with clinic patients, but from a taking over of varying ideal-type conceptions of the relationship that are held by different subgroups in the student body. A basic dichotomy exists. By some, the patient is perceived as central with the dental work secondary. Others instead see the work as primary with the patient being of secondary importance.

Moreover, within each of these two broad orientations, there is a further and important distinction made. Thus, among those who are patient-oriented, there are those who perceive patients as means to an end, and those who see them as ends in themselves. The former involves an instrumental view of patients. Patients are important because they are the means whereby the student can progress through school. Patients are acted toward and evaluated on the basis of how well they serve the student in accomplishing this personal goal.

In contrast are the other dental students who also are patient-oriented. To these the patients are important in themselves. The relationship is consequently broadly viewed, and the patient is treated as a human being in addition to the narrower role of patient. This sometimes leads to actions toward such patients that are dictated by other than strictly dental considerations. This is illustrated by an example given by one of our respondents.

> "Now take the 68-year-old woman I was telling you about. She had a comparatively good mouth for a woman of her age. In theory she should have had two gold inlays put into her. That was what the theory said and I agreed with all that. But it was not fair to subject her to all that. From the human viewpoint and this is what I would have done in private practice, was to put a silicate in. It's not the best filling but it would save her a heck of a lot of trouble and it would cost her only $3 or $4. Heck, she might not last another year so why make her go through all that trouble. The theory was right but I don't think it was fair to her as a person. I

ended up working it so that everything has been postponed for six months and then we'll see."

In contrast with this somewhat personalized kind of relationship are those relationships manifested by work-oriented student-dentists. They are of a much more impersonal nature. Here also there are two subtypes. Some of the work-oriented view patients as showcases for the exhibition of the technical skills of the practitioner. Students who are particularly interested in the mechanical aspects of dentistry are especially prone to think in this way. For them, manikins would serve the purpose equally well. In fact, some of our respondents indicated a preference for inanimate objects since they presented less of a hinderance to the exhibition of technical competence than did live patients.

The other type of work-oriented dental student sees patients primarily as living examples of basic dental problems and knowledge. Relationship to patients is governed by the extent to which various patients provide graphic examples of what dentistry is concerned with and the problems posed for study and research. In a way, these dental practitioners relate themselves much more to the dental ailment than they do to the person with the ailment. However, unlike the technic-oriented, these student-dentists are more interested in dental fundamentals than they are in applications of dental knowledge. In this respect they are the most distant of all from patients.

The outlook upon the patient-practitioner relationship, to a considerable extent, is also associated with perception of dentists and dentistry. Thus, those who take an instrumental view of patients see dentistry more or less as a job, while those who think of patients as persons to be helped see it as more of a humanitarian calling. Those who view patients as showcases for exhibitions of their skill perceive the dentist as a technician, but those who see patients as examples of dental problems and knowledge view the dentist as somewhat of a scientist.

Images of Patients

A learned characteristic of human perception is the seeing of other people as members of general categories rather than as particular personalities.[12] Such categorizing is stereotyping. You have learned to see an individual as male or female, white or Negro, young or old, and so on, so that you respond to that category before you respond to particularistic and more unique characteristics. This kind of social typing has a functional usefulness in everyday living. It saves time and effort to respond to a category. True, such categorizing leads sometimes, as in the instance of racial categories, to major errors of judgment and failure to see the qualities of the actual person involved. There is this negative consequence of the use of stereotypes. However, as indicated, stereotypes should not be considered as totally dysfunctional for social interaction.

All of this applies to the student-dentist. Like everyone else he learns stereotypes. Some of the results of this are positive in that they enable him to do his work quicker and more efficiently. Some stereotyping, on the other hand, is negative in that it hinders what he is trying to do.

Although few students seem to realize it, they learn from more advanced students to distinguish various types of patients, or in our terminology, perceive patients in stereotypic terms. They are not much more aware that they also learn, through interaction with other students, the tactics that can be used to cope with problems posed by patients stereotyped in different ways. To show what is involved in such perceptions and

reactions, a short examination is made here of one of the most prevalent stereotypes.

There is the stereotype of the "talkative" patient, the person who continually verbalizes. This type is seen as presenting a twofold problem. The vocal activity itself is an obstacle to doing any dental work in the mouth. Furthermore, the "talker" may challenge the superordinate status of the student-dentist by questioning the procedures to be followed. The general tactic learned by student-dentists to handle such types of patients is the very simple one of physically preventing the patient from vocalizing. As two different respondents said:

"I had to learn one thing. That was to prevent patients from talking too much. I wanted to be friendly at first, but there are some women particularly who will talk your ear off if you give them a chance. Sometimes to shut them up you have to put things in their mouths. Or you use something like the rubber dam for a purpose other than that for which it is intended. When it's mounted in the mouth, the person can't talk."

"There are some people that are talking all the time. I don't mind that but I found out that some of them just take the opportunity to argue some point or another with you. Well I wasn't going to stand for that. So now when I get one of those patients, I just stick an instrument or another in their mouths. They can't answer back and they have to listen."

Clearly such a tactic is functional in that it allows the typically hard-pressed student to proceed, whereas he might otherwise use clinic time he can ill afford. On the other hand, through this tactic, some patients are frustrated in obtaining those reassurances they are seeking to obtain through talking. By classifying all talkers into the same category and acting toward them in a uniform fashion, students irritate if not alienate otherwise pliable patients. Some students are not unaware of this. However the clinic situation is perceived as requiring that the establishment of rapport with patients be sacrificed to the task of getting the work done as quickly as possible.

Is what has been discussed here applicable to licensed dentists already in practice? Our study indicated that graduating seniors certainly expected to act toward patients in the way they learned to look at them while in dental school. It seems undeniable too that new dentists starting their practices would initially have the same perception of the relationship as student-dentists. However, whether changes do or do not occur is a point beyond the scope of the research data on which this paper is based. While the author would hypothesize that such changes in orientation as did occur would be minimal, this is in the realm of speculation and a definite answer will have to await some future empirical test.

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